APPLICATION FOR LICENSE TO OPERATE A RESIDENTIAL HOSPICE FACILITY

FOR OFFICE USE ONLY

Date _____

Amount _____

I. IDENTIFICATION

Name of Facility _____

Address of Facility _____

City/County/Zip _____

Telephone Number _____

Administrator _____

Date facility began operation at current address _____

Date facility began operation under current owner _____

II. CONTROL (Circle one in each column)

State	Profit	Individual
County	Nonprofit	Partnership
City		Corporation
Private		

Name and address of direct owner

_____

_____

_____

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

(OVER)

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company

III. NUMBER OF BEDS
(Residential Hospice Facility Beds)

No. Beds Licensed	No. Beds Requested

I understand that any change in the application that affects my licensure status will be reported to the Division of Community Health Services and a new application will be completed at that time.

I agree that this service and all aspects of its operation shall be open at all times to inspection by all state agency licensure personnel.

I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

Signature of Authorized Representative	Title	Date

Return application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621